

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY IN b 5 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Anne's Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall d. STREET ADDRESS None e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edgar Wha Whaples Bullen		4. DATE OF DEATH Month 10 Day 17 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/19/1888
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 12 Days 17 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Charles Bullen		14. MOTHER'S MAIDEN NAME Mary Short	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 186-16-0518	
17. INFORMANT Hospital Records		Address Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory collapse DUE TO (b) Coronary artery disease & myocardial infarction DUE TO (c) Arteriosclerosis & old myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis Contributing accident noted - fall from ladder 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Arteriosclerosis		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While working, causing wide separation of pubic bone and left sacral base fracture	
20c. TIME OF INJURY Month, Day, Year 11:55 a.m. 10-12-66		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Rock Hall Kent Md.	
21. I certify that (I) (this hospital) attended the deceased from 10/12 , 19 66 , to 10/17 , 19 66 , that (I) (we) last saw the deceased alive on 10/17 , 19 66 , and that death occurred at 12:15 P.M. M, from the causes and on the date stated above.			
22a. SIGNATURE A. C. Dick		22b. DATE SIGNED 10-17-66	
22c. PHYSICIAN'S NAME (Type) Dr. A. C. Dick		22d. ADDRESS Chestertown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 10/20/66	
23c. NAME OF CEMETERY OR CREMATORY Silverbrook Crematory		23d. LOCATION (City, town or county) (State) Wilmington, Del.	
24. FUNERAL DIRECTOR Marvin V. Williams		25a. REC'D BY REGISTRAR OCT 24 1966	
ADDRESS Chestertown, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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VR A15 (4)
15M 4-64

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14275						14274					
1. PLACE OF DEATH a. COUNTY KENT MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY KENT					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN				c. LENGTH OF STAY IN 1b 7 hrs 15 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KENT-QUEEN ANNES HOSPITAL						d. STREET ADDRESS 200 MAPLE AVENUE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HENRY HURLOCK EVANS			First Middle Last			4. DATE OF DEATH 10 1 1966			Month Day Year		
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/21/1883		9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Owner				10b. KIND OF BUSINESS OR INDUSTRY FARMER		11. BIRTHPLACE (County & State, or foreign country) QUEEN ANNES CO. MARYLAND			12. CITIZEN OF WHAT COUNTRY? AMERICA		
13. FATHER'S NAME JOHN H. EVANS						14. MOTHER'S MAIDEN NAME SALLIE ROLPH (Sarah)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 218-20-4502		17. INFORMANT HOSPITAL RECORDS CHESTERTOWN, MD					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Dissecting aneurysm of abdominal aorta</i> 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH 10 hours years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10/1, 1966, to 10/1, 1966, that (I) (we) last saw the deceased alive on 10/1 1966, and that death occurred at 11:30 PM, from the causes and on the date stated above.											
22a. SIGNATURE DR. A. C. DICK						22b. DATE SIGNED 10-1-66		22c. PHYSICIAN'S NAME (Type) DR. A. C. DICK			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/4/66		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		23d. LOCATION (City, town or county) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR J. Willis Wells						25a. REC'D BY REGISTRAR DATE OCT 4 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14276

CERTIFICATE OF DEATH

14275

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b 53 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Kent & Queen Anne's Hospital, Inc.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Nina Middle Elizabeth Last Fisher				4. DATE OF DEATH Month 10 Day 22 Year 19 66			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/29/04	
9. AGE (In years lost birthday) yrs. 62		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales (Part Time)		11. BIRTHPLACE (County & State, or foreign country) Cecil Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry H. Founds				14. MOTHER'S MAIDEN NAME Sarah Bell McMullen			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 218-20-7816		17. INFORMANT Hospital Records Address Chestertown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of liver 1561 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 6 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-30 , 19 65 , to 10-22 , 19 66 , that (I) (we) last saw the deceased alive on 10-22-66 , 19 66 , and that death occurred at 5:30 p.m. from causes and on the date stated above.							
22a. SIGNATURE A. C. Dick				22b. DATE SIGNED 10-22-66		22c. PHYSICIAN'S NAME (Type) A. C. Dick	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/24/66		23c. NAME OF CEMETERY OR CREMATORY St. Marks Cem.	
23d. LOCATION (City or Town) (County) (State) Aiken - Cecil Co. Md.				25a. REC'D BY REGISTRAR J. Willis Wells Address Chestertown, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14277 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14276

1. PLACE OF DEATH a. COUNTY Kent/ Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall (rural)		c. LENGTH OF STAY IN 1b 1-2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
3. NAME OF DECEASED (Type or print) BERNARD First Middle Last Lauriston Hardin Jr.		4. DATE OF DEATH Month October Day 31 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 28, 1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician -retired		10b. KIND OF BUSINESS OR INDUSTRY MEDICINE	9. AGE (In years last birthday) 64 yrs. IF UNDER 1 YEAR: Months 6 Days 4 Hours 3 Min.
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME B. LAURISTON HARDIN, SR.		14. MOTHER'S MAIDEN NAME ROSALIE TAYLOR SCOTT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT DORCAS H. HARDIN-3028 P. ST., N.W., WASH., D.C.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shotgun Wound of left chest DUE TO Estimated to have occurred prior to 12:00 noon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Had been gunning geese. Did not appear for lunch. DUE TO Found dead by a friend about 5:00 PM. Pronounced dead (c) dead at scene by			INTERVAL BETWEEN ONSET AND DEATH Instantaneous
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Probably self-inflicted	
20c. TIME OF INJURY Month, Day, Year 10/31/66	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) nr home	20f. (City or town) (County) (State) at Rock Hall Kent Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert W. Farr		22. DATE SIGNED October 31 1966	
EXAMINER'S NAME (Type) Robert W. Farr		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE THEREOF 11/1/66	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREM.	23d. LOCATION (City, town or county) (State) SUITLAND, MD.
24. FUNERAL DIRECTOR JOS. GAWLER'S SONS, WASHINGTON, D.C.		25a. REC'D BY REGISTRAR NOV 7 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14332

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14332

14332

STATE OF NEW YORK
COUNTY OF [illegible]
I, [illegible],
do hereby certify that on the [illegible] day of [illegible] 19[illegible]
at [illegible], New York,
I examined the body of [illegible]
and found that he/she was dead.
The cause of death was [illegible]
and the manner of death was [illegible].
I am a duly qualified and licensed medical examiner.
My commission expires on [illegible].
Signed: [illegible]
Medical Examiner
Subscribed and sworn to before me this [illegible] day of [illegible] 19[illegible].
Notary Public for the State of New York

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14277

14278

1. PLACE OF DEATH a. COUNTY XXXX Kent MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sudlersville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent and Queen Anne County Hosp.			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Hester Louise Kilson			4. DATE OF DEATH Month Day Year October 3 19 66		
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 20-1906	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Karter Jacobs		
14. MOTHER'S MAIDEN NAME Jane Kennedy			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT Address Andrew Kilson--Sudlersville, Md. RFD		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9160 DUE TO Extensive 3rd degree burns 95% of body Stove exploded, set her clothing afire. Had extensive burns as noted. Tracheotomy was performed DUE TO because of edema & fluid in respiratory tract as the result of inhalation of hot gases.					INTERVAL BETWEEN ONSET AND DEATH 14 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) See above			
20c. TIME OF INJURY Month, Day, Year 3:00 P.M. 10/21/66	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Sudlersville	(County) Queen Anne	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Robert W. Farr			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Robert W. Farr			DATE SIGNED 10/3/66		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 4	22c. NAME OF CEMETERY OR CREMATORY Burrisville Cemetery		22d. LOCATION (City, town, or county) (State) Burrisville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Kane			ADDRESS Church Hill, Md.		
24a. REC'D BY REGISTRAR DATE OCT 5			24b. REGISTRAR'S SIGNATURE Charles Judge		

MEDICAL CERTIFICATION

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10227

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10227

1. NAME OF DECEASED JOHN J. ROBERTS		2. SEX MALE		3. AGE 45	
4. DATE OF DEATH 10-15-1918		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH HOME	
7. OCCUPATION LABORER		8. CAUSE OF DEATH HEART DISEASE		9. MANNER OF DEATH NATURAL	
10. SIGNATURE OF EXAMINER JOHN J. ROBERTS		11. SIGNATURE OF WITNESSES JOHN J. ROBERTS		12. SIGNATURE OF DECEASED JOHN J. ROBERTS	
13. SIGNATURE OF DECEASED JOHN J. ROBERTS		14. SIGNATURE OF DECEASED JOHN J. ROBERTS		15. SIGNATURE OF DECEASED JOHN J. ROBERTS	
16. SIGNATURE OF DECEASED JOHN J. ROBERTS		17. SIGNATURE OF DECEASED JOHN J. ROBERTS		18. SIGNATURE OF DECEASED JOHN J. ROBERTS	
19. SIGNATURE OF DECEASED JOHN J. ROBERTS		20. SIGNATURE OF DECEASED JOHN J. ROBERTS		21. SIGNATURE OF DECEASED JOHN J. ROBERTS	
22. SIGNATURE OF DECEASED JOHN J. ROBERTS		23. SIGNATURE OF DECEASED JOHN J. ROBERTS		24. SIGNATURE OF DECEASED JOHN J. ROBERTS	
25. SIGNATURE OF DECEASED JOHN J. ROBERTS		26. SIGNATURE OF DECEASED JOHN J. ROBERTS		27. SIGNATURE OF DECEASED JOHN J. ROBERTS	
28. SIGNATURE OF DECEASED JOHN J. ROBERTS		29. SIGNATURE OF DECEASED JOHN J. ROBERTS		30. SIGNATURE OF DECEASED JOHN J. ROBERTS	
31. SIGNATURE OF DECEASED JOHN J. ROBERTS		32. SIGNATURE OF DECEASED JOHN J. ROBERTS		33. SIGNATURE OF DECEASED JOHN J. ROBERTS	
34. SIGNATURE OF DECEASED JOHN J. ROBERTS		35. SIGNATURE OF DECEASED JOHN J. ROBERTS		36. SIGNATURE OF DECEASED JOHN J. ROBERTS	
37. SIGNATURE OF DECEASED JOHN J. ROBERTS		38. SIGNATURE OF DECEASED JOHN J. ROBERTS		39. SIGNATURE OF DECEASED JOHN J. ROBERTS	
40. SIGNATURE OF DECEASED JOHN J. ROBERTS		41. SIGNATURE OF DECEASED JOHN J. ROBERTS		42. SIGNATURE OF DECEASED JOHN J. ROBERTS	
43. SIGNATURE OF DECEASED JOHN J. ROBERTS		44. SIGNATURE OF DECEASED JOHN J. ROBERTS		45. SIGNATURE OF DECEASED JOHN J. ROBERTS	
46. SIGNATURE OF DECEASED JOHN J. ROBERTS		47. SIGNATURE OF DECEASED JOHN J. ROBERTS		48. SIGNATURE OF DECEASED JOHN J. ROBERTS	
49. SIGNATURE OF DECEASED JOHN J. ROBERTS		50. SIGNATURE OF DECEASED JOHN J. ROBERTS		51. SIGNATURE OF DECEASED JOHN J. ROBERTS	
52. SIGNATURE OF DECEASED JOHN J. ROBERTS		53. SIGNATURE OF DECEASED JOHN J. ROBERTS		54. SIGNATURE OF DECEASED JOHN J. ROBERTS	
55. SIGNATURE OF DECEASED JOHN J. ROBERTS		56. SIGNATURE OF DECEASED JOHN J. ROBERTS		57. SIGNATURE OF DECEASED JOHN J. ROBERTS	
58. SIGNATURE OF DECEASED JOHN J. ROBERTS		59. SIGNATURE OF DECEASED JOHN J. ROBERTS		60. SIGNATURE OF DECEASED JOHN J. ROBERTS	
61. SIGNATURE OF DECEASED JOHN J. ROBERTS		62. SIGNATURE OF DECEASED JOHN J. ROBERTS		63. SIGNATURE OF DECEASED JOHN J. ROBERTS	
64. SIGNATURE OF DECEASED JOHN J. ROBERTS		65. SIGNATURE OF DECEASED JOHN J. ROBERTS		66. SIGNATURE OF DECEASED JOHN J. ROBERTS	
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70. SIGNATURE OF DECEASED JOHN J. ROBERTS		71. SIGNATURE OF DECEASED JOHN J. ROBERTS		72. SIGNATURE OF DECEASED JOHN J. ROBERTS	
73. SIGNATURE OF DECEASED JOHN J. ROBERTS		74. SIGNATURE OF DECEASED JOHN J. ROBERTS		75. SIGNATURE OF DECEASED JOHN J. ROBERTS	
76. SIGNATURE OF DECEASED JOHN J. ROBERTS		77. SIGNATURE OF DECEASED JOHN J. ROBERTS		78. SIGNATURE OF DECEASED JOHN J. ROBERTS	
79. SIGNATURE OF DECEASED JOHN J. ROBERTS		80. SIGNATURE OF DECEASED JOHN J. ROBERTS		81. SIGNATURE OF DECEASED JOHN J. ROBERTS	
82. SIGNATURE OF DECEASED JOHN J. ROBERTS		83. SIGNATURE OF DECEASED JOHN J. ROBERTS		84. SIGNATURE OF DECEASED JOHN J. ROBERTS	
85. SIGNATURE OF DECEASED JOHN J. ROBERTS		86. SIGNATURE OF DECEASED JOHN J. ROBERTS		87. SIGNATURE OF DECEASED JOHN J. ROBERTS	
88. SIGNATURE OF DECEASED JOHN J. ROBERTS		89. SIGNATURE OF DECEASED JOHN J. ROBERTS		90. SIGNATURE OF DECEASED JOHN J. ROBERTS	
91. SIGNATURE OF DECEASED JOHN J. ROBERTS		92. SIGNATURE OF DECEASED JOHN J. ROBERTS		93. SIGNATURE OF DECEASED JOHN J. ROBERTS	
94. SIGNATURE OF DECEASED JOHN J. ROBERTS		95. SIGNATURE OF DECEASED JOHN J. ROBERTS		96. SIGNATURE OF DECEASED JOHN J. ROBERTS	
97. SIGNATURE OF DECEASED JOHN J. ROBERTS		98. SIGNATURE OF DECEASED JOHN J. ROBERTS		99. SIGNATURE OF DECEASED JOHN J. ROBERTS	
100. SIGNATURE OF DECEASED JOHN J. ROBERTS		101. SIGNATURE OF DECEASED JOHN J. ROBERTS		102. SIGNATURE OF DECEASED JOHN J. ROBERTS	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14279

CERTIFICATE OF DEATH

14278

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Kennedyville c. LENGTH OF STAY IN ID d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Kent c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Kennedyville d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RALPH Middle E. Last MILLER.				4. DATE OF DEATH Month October Day 9 Year 19 66					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 2, 1897		9. AGE (In years last birthday) 69 yrs. IF UNDER 1 YEAR: Months 14 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming.		11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Miller				14. MOTHER'S MAIDEN NAME Mary E. Meir.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Rural Mrs. Elizabeth Miller, Kennedyville, Md. 21645			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probably Myocardial Infarction 4201 DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) (DR. W. FARR, ATTENDING PHYSICIAN, OUT OF TOWN)								INTERVAL BETWEEN ONSET AND DEATH 0	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Previous Myocardial Infarction - Diabetes Mellitus								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 59				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-9-1966 , 19 59 to OCT, 1966 , that (II) (we) last saw the deceased alive on 10-9-1966 , and that death occurred at 5 M, from the causes and on the date stated above.									
22a. SIGNATURE O. S. GULBRANDSEN, MD.				22b. DATE SIGNED 10-11-66		22c. PHYSICIAN'S NAME (Type) O. S. GULBRANDSEN, MD. CHESTERTOWN, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Oct. 13, 1966		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION (City, town or county) (State) Chestertown, Kent Co; Md.	
24. FUNERAL DIRECTOR ADDRESS Edward Fellows, Millington, Md.				25a. REC'D BY REGISTRAR DATE OCT 13 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07548

■ **CONCLUSIONS**

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Address:

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• *Journal of Management Education* 25(1): 10-17

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May 1, 1968 Chester County

CHARTERED, 1891, No. 1

WILLIAM

CONFIDENTIAL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14280

Reg. Dist. No. 14279

1. PLACE OF DEATH a. COUNTY Kent County, Maryland MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown, Maryland			
c. LENGTH OF STAY IN 1b Lifetime				d. STREET ADDRESS 345 Calvert Street			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) At Home				e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Thomas First T. Middle Richardson Last				4. DATE OF DEATH Month 10 Day 26 Year 1966			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/3/1914	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 14 Days 1		IF UNDER 24 HRS. Hours 1 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Repair				10b. KIND OF BUSINESS OR INDUSTRY Shop		11. BIRTHPLACE (State or foreign country) Maryland	
						12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Richardson				14. MOTHER'S MAIDEN NAME Georgeanna Cotton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-16-1266		17. INFORMANT Address R.F.D. Mrs. Mary Cooper Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probably congestive heart failure 4341 DUE TO (b) (Dyspnea - cough - edema for preceding 3 weeks) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Seen by Dr. Wm. H. Burkett 10/20/66							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE [Signature]				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) D. S. Gulbrandsen M.D. Actg				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Chestertown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/29/1966		22c. NAME OF CEMETERY OR CREMATORY Asbury Methodist Cem.		22d. LOCATION (City, town, or county) (State) Near Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature]				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE NOV 2 1966	
						24b. REGISTRAR'S SIGNATURE [Signature]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>14281</p> </div> <div> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>14280</p> </div> </div>											
1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY IN 1b Lifetime						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chestertown d. STREET ADDRESS Kent St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Lulu E. Startt First Middle Last						4. DATE OF DEATH 10/4/66 Month Day Year					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/19/1885		9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Kent Co. Md.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Emory Crouch						14. MOTHER'S MAIDEN NAME Mary E. Neal					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 217 54 5316		17. INFORMANT son		Address Charles Startt Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Complications of old age DUE TO (b) Cerebral thromboses DUE TO (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH 3 months Several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 8-15 , 19 66 , to 10-4 , 19 66 , that (I) (we) last saw the deceased alive on 10-3 19 66 , and that death occurred at 8:00 AM, from the causes and on the date stated above.											
22a. SIGNATURE A. C. Dick						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/4/66			
22c. PHYSICIAN'S NAME (Type) A. C. Dick						22d. ADDRESS Chestertown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/6/66		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery				23d. LOCATION (City, town or county) (State) Chestertown, Md.			
24. FUNERAL DIRECTOR William Wells						ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR OCT 7 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14282					14281				
1. PLACE OF DEATH a. COUNTY KENT					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY KENT				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN			c. LENGTH OF STAY IN 1b 25 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KENT-QUEEN ANNES HOSPITAL					d. STREET ADDRESS Lankford			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WALTER			First Middle Last LEE WALBERT		4. DATE OF DEATH 10 15 1966				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-26-1894		9. AGE (In years last birthday) 72 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) QUEEN ANNES CO. MARYLAND		12. CITIZEN OF WHAT COUNTRY? AMERICA	
13. FATHER'S NAME THEODORE LANDON WALBERT					14. MOTHER'S MAIDEN NAME JOSEPHINE REBECCA JOLLY				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 214-32-1568		17. INFORMANT HOSPITAL RECORDS Address CHESTERTOWN, MD.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 6000 DUE TO Pyelonephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 9/20 , 19 66 , to 10/15 , 19 66 , that (I) (we) last saw the deceased alive on 10/15 , 19 66 , and that death occurred at 5:15 PM , from the causes and on the date stated above.									
22a. SIGNATURE A. T. Keefe					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10.15.66		
22c. PHYSICIAN'S NAME (Type) DR. A. T. KEEFE					22d. ADDRESS CHESTERTOWN, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/17/66		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION (City, town or county) (State) Chestertown, Md.			
24. FUNERAL DIRECTOR Harmon V. Williams				ADDRESS Chestertown Md.		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE OCT 24 1966									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Millington c. LENGTH OF STAY IN 1b 14 - 1 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Kent. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Millington d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JULIA V. WALLACE.			First Middle Last		4. DATE OF DEATH Month October Day 22 Year 19 66		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH March 21, 1888 9. AGE (In years last birthday) 78 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Millington, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Joseph H. Moffett					14. MOTHER'S MAIDEN NAME Araminta Gordon					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes give war or dates of service)			16. SOCIAL SECURITY NO. 220-16-7610		17. INFORMANT Herman Wallace, Address Millington, Md. 21651					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphocytic Leukemia 2040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 30 months		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from September, 1961 , to 10-22, 1966 , that (I) (we) last saw the deceased alive on 10-14 1966 , and that death occurred at 1:30 p.m. from the causes and on the date stated above.										
22a. SIGNATURE A.C. Dick. M.D.					22b. DATE SIGNED 10-24-66		22c. PHYSICIAN'S NAME (Type) A.C. Dick. M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF Oct. 25, 1966		23c. NAME OF CEMETERY OR CREMATORY Galena Cemetery		23d. LOCATION (City, town or county) (State) Galena, Kent Co; Md.	
24. FUNERAL DIRECTOR Edward Fellows, ADDRESS Millington, Md. 21651					25a. REC'D BY REGISTRAR OCT 26 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14284 CERTIFICATE OF DEATH 14283

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>				c. LENGTH OF STAY IN 1b <u>29 Hours</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Kent & Queen Anne's Hospital, Inc.</u>				e. STREET ADDRESS <u>Box 325A</u>			
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>Reeder</u> Last <u>Wise</u>				4. DATE OF DEATH Month <u>10</u> Day <u>18</u> Year <u>19 66</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9-16-1899</u>	9. AGE (In years last birthday) <u>67</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Woodworking/Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Woodworking</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Lancaster Co., Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Walter W. Wise</u>			
14. MOTHER'S MAIDEN NAME <u>Mamie Brown</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. <u>207-01-5236</u>				17. INFORMANT <u>Hospital Records</u> Address <u>Chestertown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure & pulmonary edema</u> <u>4222</u> DUE TO (b) <u>Chronic myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>10/17</u> , 19 <u>66</u> , to <u>10/18</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/18</u> , 19 <u>66</u> , and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Dr. A.C. Dick</u>				22b. DATE SIGNED <u>10-18-66</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. A.C. Dick</u>	
22d. ADDRESS <u>Chestertown, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/22/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mellinger Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Lancaster, Pa.</u>	
24. FUNERAL DIRECTOR <u>W. Willis Wells</u> ADDRESS <u>Chestertown, Md.</u>				25a. REC'D BY REGISTRAR <u>OCT 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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